

## Section G: Functional Status



- ADL's Drive Care –
- Assess need for assistance with ADLs, altered gait & balance, & decreased range of motion
- Resident & staff opinions re: functional rehab potential
- Very Important Section – 35 pages long
- **A major target of the OBRA process is to “maintain or attain highest practicable well-being” of the resident**

## Section G0110: ADLs



- ADL's - Self-performance & support
- Self Performance measures what resident actually did, not what one believes they are capable of doing – See Algorithm page G-6
  - **Code based on adaptive devices if used**
- Support Provided measures highest level of support provided by staff while resident performing the ADL

## Bed Mobility – G0110A



- How the resident:
  - Moves to & from a lying position
  - Turns side to side, and
  - Positions body while in bed or alternate sleep furniture (whatever resident sleeps in)

**5 coding Examples –pages G-9 & 10.  
Review differences between #2 & #3**

## Transfer - G0110B



- How resident moves between surfaces
  - to/from bed, chair, wheelchair, standing position
- **Exclude** movement to/from toilet or bath, which is covered under toilet use and bathing

**6 coding Examples – pages G-10 & 11.  
Review use of mechanical lift in example #5**

### Walking - G0110C, G0110D

- **In Room:** How resident walks between locations in their room (**only**)
- **In Corridor:** How resident walks in corridor on unit (only)



*\*This question does not address whether the resident walks or not, it asks if the walking occurred in his room or unit corridor*

**5 coding Examples for each item – pgs. G-11 thru 13. Review example #5, pg. G-12 coded (8) & example #5 pg. G-13 coded (7).**

### Locomotion - G0110E, G0110F

- **On Unit:** How resident moves between locations in their room & adjacent corridor on same floor. **If in w/c**, self-sufficiency once in chair
- **Off Unit:** How resident moves to & returns from off-unit locations (areas set aside for dining, activities, etc.)
  - If facility has only one floor, how resident moves to & from distant areas on the floor.



**1 On Unit example pg. G-13. 3 Off Unit examples pg. G-14. Review #1 for both – ea. coded (8).**

### Dressing – G0100G

- How resident puts on, fastens, takes off all items of clothing, **including donning/removing a prosthesis or TED hose.**
- Includes putting on & changing pajamas, & house dresses



**1 coding example pg. G-14.**

### Eating – G0100H

- How resident eats & drinks, regardless of skill
- Do not include eating/drinking during medication administration
- Includes nourishment by any means, e.g.:
  - Oral, tube feeding, tpn, IV's given for hydration/nutrition



**6 coding examples – pgs. G-15 & 16. Review coding of tube feeding example #6.**

## ADL Coding--Eating



- **Special rules for eating**

- General supervision of dining room is **not** coded as “Supervision”
- Code “1 - Supervision” for residents seated together or in close proximity of one another during a meal who all receive supervision with eating

See pg. G-7 for rules about “Eating & Supervision” and pg. G-8 for examples re: tube- feedings.

## Toilet Use – G0100I



- How resident uses the toilet room, commode, bedpan, or urinal
  - **Does not include staff emptying of elimination devices (bedpan, urinal, bedside commode, catheter bag or ostomy bag)**
- How resident transfers on/off toilet, cleanses self, changes pad, manages ostomy or catheter, & adjusts clothing.

**5 coding examples pgs. G-16 & 17.**

## Personal Hygiene – G0100J



- **Includes:**

- Combing hair, brushing teeth
- Shaving, applying makeup
- Washing/drying face, hands

- **Excludes:**

- Baths & Showers which is covered in bathing ADL

**2 coding examples pg. G-17.**

## Section G0110:ADL Self Performance

- **Independent (0)** – means all the time – may have set-up help – see example pg. G-9.
- **Rule of Three:**
- **When an activity occurs 3 times at any one level, code that level**
- **When an activity occurs 3 times at multiple levels, code the most dependent**
- **Exceptions** are: total dependence (4) & did not occur (8) – these are all the time events

### Section G0110:ADL Self Performance

- **Rule of Three, cont.**
- When an activity occurs at various levels, but not 3 times at any given level do the following:
  - If combination is full staff performance (4) and extensive assist (3) = code extensive (3)
  - If combination is full staff performance (4), wt. bearing assistance (3), and/or non-wt bearing assistance (2) = code limited (2)
  - If none of above are met, code supervision (1)

### Section G0100: ADL Self Performance

- **Self Performance: past 7 days**
  - 0 = Independent** – no help/oversight **every** time
  - 1 = Supervision** – oversight, encouragement or cueing provided 3 or more times
  - 2 = Limited** – resident highly involved, physical help in guided maneuvering of limbs or other non-wt bearing assistance 3 or more times
  - 3 = Extensive** – resident involved, but staff provide wt. bearing support. Also other combinations – see Algorithm page G-6

### G0110: ADL Self-Performance cont.

- 4 = Total Dependence** – full staff performance with no resident participation for any part of ADL every time
- 7 = Activity occurred only once or twice** NEW
- 8 = Activity did NOT occur**
  - Toileting-use 8 only if no elimination occurred
  - Locomotion-use only if resident on bed rest
  - Eating-use only if no nourishment was provided by any route

### ADL Coding Example – Self Performance

- 7-day look back period

7-3: 2,1,2,0,1,2, 0

3-11: 2,1,2,3,1,0, 2

11-7: 0,1,3,0,3,0, 0

0's = 7

1's = 5

2's = 6

3's = 3

Code this ADL a "3"

- **Rule: When an activity occurs 3 times at multiple levels, code the most dependent**
- **You do not "average" the scores; it is a matter of what level was present 3 or more times**

### Rule of “4’s” – Self Performance

- To code a “4” for self performance the resident must have never participated in any part of the ADL over the entire 7 day observation period.

7-3: 4444444

3-11: 4444344

11-7: 4344444

Code this as a “3”

### Section G0110: ADL Staff Support

- **Coding Staff support**
  - Code for **most dependent even if that level was only provided 1 time** during past 7 days
  - **Code Independently from self performance codes**
  - 0** = no setup or physical help from staff
  - 1** = setup help only
  - 2** = one person physical assist
  - 3** = 2+ person physical assist
  - 8** = ADL did not occur during entire period

### G0100: General ADL Coding Tips

- Do not code ADLs based on what resident should receive or their potential, but on what they DID
- **Do not include assistance provided by family or other visitors**
- For residents with tube feeding, TPN or IV fluids, MDS coding depends on the amount of resident’s participation in process of “eating”

### Coding Scenario #1

- Mr. J is able to transfer himself from the wheelchair to bed by himself. Once on the bed, however, he is not able to lie down without help from staff due to lower extremity edema. Each evening during the 7-day look-back period one nursing staff lifts Mr. J’s legs up & places them on the bed. After that, Mr. J is able to turn & reposition himself independently.
- **How would you code bed mobility?**

### Coding Scenario #2

Mrs. R requires extensive assistance with all ADLs & assistance of 2 staff. She spends all of her time in bed with the exception of a weekly outing to a music program in activity room. During the past 7 days, 2 staff transferred the resident from her bed to a wheelchair & then back to bed when activity was over.

- How would you code the Transfer ADL?

### Coding Scenario #3

- Resident is reminded by one staff person to toilet frequently during the day, once in the bathroom reminded to unzip & zip up his pants & to wash his hands when toileting is complete.
- The resident required this same process several times daily throughout the entire 7-day look-back period.
- How would you code the toilet use ADL?

### Section G0120: Bathing



- **Rule of 3 does not apply**
  - Code for maximum amount of assistance received during bathing
- Codes for support provided are the same as other ADL's
- Excludes washing back, hair
- **If facility policy is: supervise all residents during bathing, then even independent people are coded "1-supervision" in self-performance**

What if only family member bathes resident?

### G0300: Balance During Transitions & Walking (New item)

- Individuals with impaired balance & unsteadiness during transitions & walking
  - are at increased risk for falls; often afraid of falling; and may limit physical & social activity; can become increasingly immobile
- Those with impaired balance & unsteadiness should be evaluated for
  - Rehabilitation or assistive devices;
  - Supervision or physical assistance for safety;
  - Environmental modification

### G0300: Balance, cont.

- Conducting the assessment
  - Can be done through observations of resident during entire 7-day look-back period
  - During transitions from sitting to standing, walking, turning, transfers on & off toilet, & transfer from w/c to bed & bed to w/c
  - Documentation must reflect resident's stability in these activities at least once during look-back, otherwise the following assessment must be done.

### G0300: Balance Assessment

- Have assistive devices normally used available
- Start with resident sitting on edge of bed, in a chair or in a wheelchair
- Ask resident to stand up & stay still for 3-5 seconds (**rate G0300A now**)
- Ask resident to walk approximately 15 feet using their usual assistive device (**rate G0300B now**)
- Ask resident to turn around (**rate G0300C now**)

### G0300: Balance Assessment, cont.

- **Ask resident to:**
  - walk or wheel from a starting point in their room into the bathroom
  - prepare for toileting as normally do (taking down pants or other clothing, but leaving undergarments on)
  - sit down on the toilet (**rate G0300D now**)
  - to transfer from a seated position -chair or w/c
  - to seated position on bed (**rate G0300E now**)

### G0300: Balance Coding

- **0** = steady at all times (no risk of falls)
  - If **assistive device used**, did resident appropriately plan & integrate it's use into the transition activity
- **1** = not steady, able to stabilize without staff assistance (increased risk of falls)
- **2** = not steady, only able to stabilize with staff assistance (high risk of falls)
- **8** = activity did not occur



### G0400: Functional Limitation in Range of Motion

- Intent to identify limitations that interfere with daily functioning or place resident at risk of injury
- Assess ROM at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot & other joints unless contraindicated (both sides of body)
- Ask resident to move each joint using verbal directions & demonstration. May actively assist the resident with ROM exercises.

### G0400: Limitation in ROM Coding

- **0 = no impairment**
  - Resident has full functional ROM on both sides, upper & lower extremities (UE/LE)
- **1 = impairment on one side**
  - UE and/or LE impairment on 1 side of body & interferes with daily functioning, or places resident at risk of injury
- **2 = impairment on both sides**
  - UE and/or LE impairment on both sides of body & interferes with daily functioning or places resident at risk of injury

### G0900: Functional Rehab Potential

- **G0900A** – Resident believes they are capable of increased independence in at least some ADLs
  - 0 = No**, resident believes they will stay the same
  - 1 = Yes**, resident thinks improvement possible
  - 9 = unable to determine**, resident cannot indicate
- **G0900B** – Direct care staff believe resident capable of increased independence in at least some ADLs
  - 0 = No**
  - 1 = Yes**

Code what is stated even if it appears unrealistic



### Section H: Bladder & Bowel past 7 days

NEW

- Assess /provide individualized tx. & services to achieve/maintain as normal elimination function as possible
- Use of bowel & bladder appliances; response to bowel & urinary toileting programs
- Know what appliances are in use & history & rationale for their use
- **Care Planning** – include interventions consistent with goals & minimize complications with any B&B appliances

Section H – Bladder & Bowel

**H0100A-D - Appliances - past 7 days**  
~ Check all that apply

- **H0100A, indwelling catheter** (includes suprapubic catheter & nephrostomy tube)
- **H0100B, external catheter**
- **H0100C, ostomy** (e.g. urostomy, ileostomy, & colostomy)
- **H0100D, intermittent catheterization**  
– NOT a one-time cath for UA specimen 
- **H0100Z, none of the above**

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**H0200A - C**  
**Urinary Toileting Program (TP)**

- **Individualized, resident-centered** TP may decrease or prevent urinary incont., minimize or avoid negative consequences of incontinence
- Determine type of urinary incontinence; **provide more individualized** programming/interventions to enhance quality of life & functional status
- Many incont. residents (e.g. those w/dementia) may respond to a TP, especially during daytime

Section H – Bladder & Bowel



**MDS 3.0**  
**Coding Tips re: Toileting Program (TP)**

- TP refer to specific approach; organized, planned, documented, monitored, & evaluated
- Consistent with NH's policies & procedures & current standards of practice. **TP is NOT:**
  - **simply tracking continence status, &**
  - **changing pads or wet garments**
  - **random assistance with toileting or hygiene**

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**MDS 3.0 Coding Tips**  
**H0200A- Toileting Program (TP)**

- **The Look-Back period for trial of TP:**
  - The most recent admission/readmission
  - The most recent prior assessment, or
  - To when incontinence was first noted

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### H0200A-C: Urinary (TP) cont.

- **H0200A - Has a Trial of a TP** (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted **on admission/reentry or since urinary incontinence noted in this facility?**
  - Observed for at least 3 days (pg H-4)
- **H0200B** – Response –to Trial TP
- **H0200C** – Current Toileting Program or trial

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### ➤ H0200A: Has a trial of a TP been attempted?

- **0 = No: Not attempted.** Includes continent with /without toileting assistance, permanent cath. or ostomy use, or any who prefer not to participate.  
➡ **Skip to Urinary Continence H0300**
- **1 = Yes:** Trial attempted of individualized, resident-centered toileting program at least once
- **Code 9, unable to determine:** No info. or records for determination.

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### ➤ H0200A: Urinary Toileting Trial Reminders

- Voiding diary/records detect patterns/intervals between incontinence episodes & facilitate reducing frequency
- **Simply tracking** continence status with records/diary isn't an **individualized**, resident-centered TP
- **Reevaluate** whenever a change in cognition, physical ability, or urinary tract function
- **Reevaluate** ability to participate in toileting trial or, if one toileting trial unsuccessful, need for a different TP.

Observe for at least 3 days –pg. H-4

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### ➤ H0200B: Resident's response to Trial Program? - Reminders

- **0 = no improvement:** Frequency of urinary incont. didn't decrease
- **1 = decreased wetness:** Frequency decreased, but remained incont. Improvement should be clinically meaningful—e.g., at least 1 less incont. void /day than before TP implemented.
- **2 = completely dry (continent):** No episodes of incont. If more than 1 TP trial, use most recent trial.
- **Code 9, unable to determine or trial in progress.**

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➤ **H0200C: Current Toileting Program/Trial Reminders**

➤ **Is TP being used to manage urinary incontinence?**

- **0 = no:** individualized resident-centered TP (i.e., prompted voiding, scheduled toileting, or bladder training) used less than 4 of past 7 days
- **1 = yes:** managed during 4 or more of past 7 days w/ some type of systematic TP (bladder rehab., bladder retraining, prompted voiding, habit training/scheduled voiding). **Daytime only TP is OK.**

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**H0300 – Urinary Incontinence**  
7 day look-back

➤ **H0300 - code that best describes resident**

- **0 = Always continent**
- **1 = Occasionally incontinent** - < 7 episodes of incontinence
- **2 = Frequently incontinent** = 7 or more , but at least 1 episode of continent voiding
- **3 = Always incontinent** – no continent voiding
- **9 = Not rated** – had catheter (indwelling or condom), ostomy, or no urine output

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**Example #1 - Toileting Program (TP)**

- **Mrs. H.** –advanced Alzheimer’s. Total ADL Dependent. No cognitive ability to void in toilet / other appropriate receptacle. Totally incontinent. Voiding assessment /diary indicates no incont. pattern. Care Plan: due to total incont., staff follow NH standard incont. policy = check & change every 2 hrs. while awake, apply super-absorbent brief at bedtime so sleep is not disturbed.

- **Code: H0200A = 0, no**
- **H0200B & H0200C would be skipped.**

Updated

- **Rationale: No pattern to incontinence = H0200A = 0. Due to total incontinence, a TP is not appropriate for this resident. Skip to H0300.** Staff provide supportive care in accordance with NH policy.

**Example #2 - Toileting Program (TP)**

- **Mr. M.** – dx. CHF & hx. of L-sided hemiplegia (stroke). Increase in urinary incont. Assessed for reversible cause of incont. & evaluated voiding pattern with voiding assessment /diary. Determined incont. episodes could be reduced. Plan developed = toileting every hr. for 4 hrs. after receiving 8 a.m. diuretic; then every 3 hrs. until H.S. at 9 p.m. Staff communicated TP to Mr. M. Staff placed interventions in Care Plan –also reevaluated response after 1 mo. & adjusted as needed.

Updated

- **Coding: H0200A = 1, yes. H0200B = 9, unable to determine, trail in progress. H0200C = 1, yes - current TP or trial.**

- **Rationale:** Voiding pattern assessed & individualized plan developed & communicated to resident & staff.

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### H0400 – Bowel Incontinence (7 day look-back)

➤ **H0400 - code that best describes resident**

**0 = Always continent**

**1 = Occasionally incontinent** – 1 episode

**2 = Frequently incontinent** = 2 or more, but at least 1 episode continent bowel movement

**3 = Always incontinent** – no continent bm

**9 = Not rated** – had ostomy, or no bm for entire 7 days (should check for fecal impaction & evaluated for constipation)

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### H0500 – Bowel Toileting Program (TP) 7 day look-back

➤ **Is a Toileting Program currently being used to manage resident's bowel continence?**

- **0 = no:** Resident **not** currently on a TP targeted specifically at managing bowel continence.
- **1 = yes:** Resident currently on a toileting program targeted specifically at managing bowel continence.

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### H0600 – Bowel Patterns (7 day look-back)

➤ **H0600 – Constipation present?**

• **0 = no:** Resident shows no signs of constipation during the look-back period

• **1 = yes:** Resident shows signs of constipation during the look-back period.

➤ Unaddressed constipation can lead to fecal impaction. May be manifestation of serious conditions, e.g., dehydration, inadequate fluid intake, & Rx. side effects

➤ Fecal impaction is Constipation

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### H0200 Scheduled Toileting Plan

-  Scheduled – activity performed according to specific, routine time **communicated** clearly to resident & caregivers
-  Toileting – voiding/ having bm in bathroom, commode or other **appropriate** receptacle
-  Program – **resident specific** approach, organized, planned, documented, **monitored & evaluated**

All Key components must be present in order to code

NO Change



### **Section H – remember**

- A generic, facility policy for “**scheduled check & change**” plan is not the MDS/CMS intent
- TP meant to capture planned programs to assist residents work toward getting back, as much as possible, or maintaining, self-control (continence) of bladder /bowel
- CMS has information & guidance on toileting & bladder re-training programs - Refer to the State Operations Manual (SOM), Survey tag F315 (42 CFR 483.25(d) (2) re: urinary incontinence



### **Section H: Bladder & Bowel – a Care Plan Should:**

- Include interventions consistent with goals & minimize complications with any B&B appliances
- Based on assessment & evaluation of H&P exam, Dr. orders, progress notes, Nurses' notes & flow sheets, Pharmacy & lab reports, voiding hx., overall condition, risk factors, continence/catheter status, environmental factors, & response to continence/catheter

Section H – Bladder & Bowel

### **Section I - Active Diagnoses**

- Code diseases with a relationship to resident's:
  - Current functional status,
  - Cognitive status,
  - Mood or behavior status,
  - Medical treatments,
  - Nursing monitoring,
  - Risk of death



Section I – Active Diagnoses

### **Section I – Active Diagnoses**

- Increased from 44 to 56 diagnoses choices & 17 new diagnoses
- Some deleted – e.g. – “other cardiovascular...”
- Some dx.s combined –e.g. hypo/hyperthyroidism
- Some new or revised categories – “Nutritional”
- Now 10 slots to code “additional” ICD-9 codes
- Section I repeated on all MDS 3.0 assessment forms except “Death in facility” discharge form

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### Section I - Active Diagnoses, cont.



- There are 2 look-back periods: 7 & 60 day
- **Step 1-** Diagnosis identification /documented by authorized clinicians in **past 60-days**
  - Physician and/or Physician Assistant
  - Nurse Practitioner, or Clinical Nurse Specialist
- **Step 2 -** Determine dx. status – Active or Inactive – **past 7-days**
- Review medical record:
  - Transfer/discharge summaries, recent H&P, Dr's orders & progress notes, Nursing & all IDT notes, Rx. records, Consults, Lab & diagnostic reports,

Section I– Active diagnoses

### Section I - Active Diagnoses, Confirmation

- **If specific documentation absent for active dx., (past 7 days) - following indicators may be used:**
- E.g.: test /procedure, hospitalization for acute symptoms &/or recent change in therapy, X-ray; hospital d/c summaries, etc.
- Signs & symptoms: productive cough confirming dx. of pneumonia (specifically noted by Dr.) ~**See MDS 3.0 manual – page I-8**
- E.g., to code arthritis “**active**” dx., check progress notes, H&P, etc. Tx. & Rx. orders for arthritis, PT & OT for rehab

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### Coding Example of Inactive Diagnoses (do not code)

- Admission hx. states Resident had pneumonia 2 mo. prior to admission. Recovered completely, no residual effects & no continued tx. In past 7 days.
- **Coding: Pneumonia** item (I2000), would **not be checked**.
- **Rationale:** Pneumonia dx. not active because of resident's complete recovery & discontinuation of any tx. during past 7 days.

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### Section I – Active Diagnoses – UTI

- **UTI = Past 30 days - differs from other items**
- **I2300 Urinary tract infection (UTI) needs:**
  - ✓ Physician diagnosis of a **UTI** in last **30 days**
  - ✓ Sign or symptom attributed to UTI
  - ✓ “Significant laboratory findings” –determined by the attending physician
  - ✓ Current medication or treatment for a UTI in the last 30 days

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### Section I – Active Diagnoses within the past 7 days

- **I7900 – None of the above active dx.**
- **I8000 – Other– Additional active diagnoses -10 lines for additional dx**
  - Write dx. & enter ICD code in boxes (Rt. justified – also Decimal point in its own box
  - **CMS Update – Sept 2010** - If a diagnosis is a V-code, another dx. for the related primary medical condition should be checked in items I0100-I7900 or entered in I8000

### Section I – Active Diagnoses

- **From August, CMS MDS 3.0 Conference**
- CMS plans to add algorithms to the manual to help code Section I (diagnoses) to help determine if a diagnosis is active or inactive
- CMS will format & post these and other tools in an Appendix in the MDS 3.0 Manual & on their Web site -

### Section J: Health Conditions



- Documents some health conditions that impact resident's functional status & quality of life
- Review the Pain assessment which uses a resident or staff interview as applicable
- Assess: presence & frequency of pain; effect on function, intensity, management & control
- Other items assess: dyspnea, tobacco use, prognosis, problem conditions, and falls

Section J– Health Conditions

### J0100A-C: Pain Management (5-Day Look Back) ← NEW

- **Coding Instructions for J0100A-C**
- Review medical record, medications sheets, etc
- Determine all interventions for pain (includes non-medication management) provided to the resident during the 5-day look-back period.
- Answer **J0100A-C** items even if the resident currently denies pain.

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**Coding Instructions for J0100A**  
(5-Day Look Back) ← **NEW**

- See **J0100A: Been on a Scheduled Pain Medication Regimen?**
- **0 = no: No** documentation a scheduled pain medication was received.
- **1 = yes: Yes** documentation a scheduled pain medication was received.



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**Coding Instructions for J0100B**  
(5-Day Look Back)

- See **J0100B: Received PRN Pain Medication**
- **0 = no: No** documentation a PRN medication was received or offered.
- **1 = yes: Yes** - documentation a PRN medication either received, OR offered, but declined.

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**Coding Instructions for J0100C**  
(5-Day Look Back) ← **NEW**

- See **J0100C: Received Non-medication Intervention for Pain**
- **0, no: NO** documentation a non-medication pain intervention was received.
- **1, yes:** Documentation present a non-medication pain intervention scheduled as part of the care plan, **and** documentation the intervention was received, **and** assessed for efficacy.

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**J0200: Should Pain Assessment Interview Be Conducted?**

- Review **B0700 and A1100**
- **Remember** - If it's not possible for interpreter to be present for interview **code J0200 = 0**, to indicate interview not attempted
- **Complete** Staff Assessment of Pain -**J0800**, **instead** of the Pain Interview



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### J0300- J0600: Pain Assessment Interview

- Since resident is asked to recall pain during the past 5 days, interview should be conducted as close to the end of the 5-day look-back period; **preferably the day before, or the day of the ARD**
- This more accurately captures pain episodes that occur during the 5-day look-back period

### J0300- J0600: Pain Assessment Interview

- If resident seems unsure/ hesitant, use other terms: e.g., hurting, aching, or burning
- If resident chooses not to answer a particular item, accept refusal, **Code 9** & move to next item
- If resident unsure about whether pain occurred in past 5 days, ask about most recent episode of pain & determine if it was within past 5 days

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### J0300- J0600: Pain Assessment Interview 4 Questions

- **1 Primary question = Pain Presence**
  - If resident unable to answer primary question, skip to Staff Assessment
- **3 Follow- up Questions:**
  - 1) **Pain Frequency - (J0400)**
  - 2) **Pain Effect on Function - (J0500)**
  - 3) **Pain Intensity - (J0600)**

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### J0300 – Pain Presence (5-day)

- **Ask resident:** “Have you had pain or hurting at any time in the last 5 days?”
- **0 = “No” - Also code 0**, if reason for no pain is resident rec’d pain management interventions
- **If J0300 coded 0, Pain Interview is complete**
- **1 = “Yes” = pain at any time;** proceed to Pain Frequency (J0400)
- **9 = unable to answer:** does not respond, or gives nonsensical response –**skip** to Staff Assessment

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### J0400 – Pain Frequency (5-day)

- May present response verbally, on a written sheet or cue card.
- Clarify best response by echoing (repeating) their comment & providing related response options
- If resident has difficulty selecting between 2 provided responses, **then select the more frequent of the two**

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### J0400 – Pain Frequency (5-day)

- Ask: “How much of the time have you experienced pain or hurting in past 5 days?”

1 = almost constantly

2 = frequently

3 = occasionally

4 = rarely

9 = unable to answer- doesn't respond, or gives a nonsensical response



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### J0500A- B – Pain Effect on Function (5-day)

- “Over the past 5 days, has pain made it hard for you to sleep at night?”
- **0 = no:** = pain didn't interfere with sleep
- **1 = yes:** = pain interfered with sleep
- **9, unable to answer:** doesn't respond, or gives nonsensical response.

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### J0500A & B – Pain Effect on Function

- “Over the past 5 days, have you limited your day-to-day activities due to pain?”
- **0 = no** = pain didn't interfere with activities
- **1 = yes** = pain interfered with activities
- **9 = unable to answer** = doesn't respond, or gives nonsensical response

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### J0600 – Pain Intensity (5-day)

- **Use only ONE** of the following pain intensity pain scales to interview about pain intensity
  - **J0600A, Numeric Rating Scale**
  - **J0600B, Verbal Descriptor Scale**
- For each resident, try to use the same scale used on prior assessments
- If resident unable to answer using one scale, the other scale should be attempted

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### J0600 – Pain Intensity (5-day)

- **See J0600 (A or B) – cont.**
- **Leave response for the unused scale blank**
- Read question & choices slowly. You may show response options (either 00 -10 or verbal descriptor scale) clearly printed on a cue card - **Use large, clear print**
- Resident may provide a verbal response, point to the written response, or both

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### J0600A – Pain Intensity (00-10)

- **See J0600A: Numeric Rating Scale (00-10)**
- For 0-10 scale, say, “Please rate your worst pain over the last 5 days with **zero** being **no** pain, and **ten** as the **worst** pain you can imagine.”
- Show resident the **00-10 pain scale**
- Enter the 2-digit response
- Enter **99** if unable to answer
- **If this scale not used, leave box blank**

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### J0600B – Verbal Descriptor Scale

- **1 = mild:**
- **2 = moderate:**
- **3 = severe:**
- **4 = very severe, horrible:**
- **9 = unable to answer:** chooses not to respond, doesn't respond, or gives a nonsensical response.
- **If this Verbal Descriptor Scale not used, leave response box blank**



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**J0700 – Should Staff Assessment for Pain be conducted (5-day)**

➤ **Complete only if Pain Assessment Interview (J0200-J0600) not completed.**

- Resident self-reporting is preferred & more reliable means of assessing pain
- If resident isn't able to, or unwilling to provide information, staff assessment is necessary
- Those unable to complete pain interview may still have pain - observe their affect during interview

**J0700 – Should Staff Assessment for Pain be conducted (5-day)**

➤ **Complete only if Pain Interview (J0200-J0600) not completed.**

- **0 = no:** Resident completed Pain Interview
- **1 = yes:** Resident unable to complete Pain Interview (J0400 = 9)

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**J0800 – Indicators of Pain (5-day)**

- Residents unable to communicate about pain are at particularly high risk for under-detection & under-treatment
- Fewer complaints may not mean less pain
- Individuals may use alternative methods of expression to communicate their pain
- If pain indicators present, identify aggravating and/or alleviating factors related to pain

**J0800 – Indicators of Pain (5-day)**

- Pay attention to indicators of pain during ADLs when pain most likely to be demonstrated (bathing, transferring, dressing, walking, wound care, therapy, etc.)
- Carefully monitor, track, & document any possible signs & symptoms of pain
- **Obtain information from: the medical record, Staff (all shifts), & observe the resident**

**J0800 – Indicators of Pain**  
Check all that apply (past 5-days)

- **Based on staff observation/ reports of pain indicators.** If J0800Z checked = no pain, proceed to **Shortness of Breath (J1100)**.
- **Check J0800A, non-verbal sounds:** e.g., crying, whining, gasping, moaning, or groaning
- **Check J0800B, vocal complaints of pain:** e.g., vocal complaints of pain (“that hurts,” “ouch,” or “stop”)

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**J0800 – Indicators of Pain cont. (5-day)**

- **Check J0800C, facial expressions:** e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw - observed/ reported
- **Check J0800D, protective body movements or postures:** e.g., bracing, guarding, rubbing, massaging body part/area, clutching/ holding body part during movement - observed/ reported
- **Check J0800Z, No signs of pain indicators:** e.g., observed, reported, or documented

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**J0850 – Frequency of Indicator of Pain or Possible Pain (5-day)**

- **Code 1:** Based on staff observation, resident complained /showed evidence of pain **1-2 days**
- **Code 2:** Based on staff observation, complained /showed evidence of pain **3-4** of the last 5 days
- **Code 3:** Based on staff observation, resident complained /showed evidence of pain **daily**

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**J1100 – Shortness of Breath (dyspnea)**

- Interview resident about SOB. Many residents, including those with mild/moderate dementia, may be able to provide feedback
- SOB can be an indication of a change in condition requiring further assessment & should be explored
- **Care plan** should address underlying illnesses that may exacerbate SOB as well as symptomatic tx.
- Check for allergies or other environmental triggers

### **J1100 – Shortness of Breath (dyspnea)**

➤ **Check all that apply (7 day item)**

- **J1100A:** SOB or trouble breathing with ADLs; activities avoided
- **J1100B:** SOB or trouble breathing - sitting at rest
- **J1100C:** SOB or trouble breathing - lying flat
- **J1100Z:** None of the above

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### **J1300 – Current Tobacco Use**

- Ask if tobacco used (any form) in past 7 days. If unable to answer or no tobacco use, verify with record review & staff interview
- **0 = No**
- **1 = Yes**

### **J1400 – Prognosis**

- Does resident have condition or chronic dx. that may result in life expectancy of < 6 months, or are they receiving hospice services? Requires physician documentation
- **0 = No**
- **1 = Yes**

### **J1550 – Problem Conditions- 7-day look-back**

- Review records, interview staff (all shifts), & observe for any indication of vomiting, fever, dehydration, or internal bleeding
- **Check all that apply**
- **J1550A** - fever
- **J1550B** - vomiting
- **J1550C** - dehydration
- **J1550D** - internal bleeding
- **J1550Z** - none of the above

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### **J1700A, B, C – Fall History on Admission prior to Admission?**

- **J1700A:** Did Resident have a fall in last month?
- **J1700B:** A Fall in past 2-6 mo.?
- **J1700C:** Any fx. r/t a fall in past 6 mo.?
- No matter where it occurred: review hospital or inter-facility transfer records
- Fall – witnessed or not, unintentional change in position, **not a result of external force**

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### J1700A, B, C – Fall prior to Admission

- Coding instructions for J1700
- **0 = No**
- **1 = Yes**
- **9, unable to determine: No information**

- Fear of falling can limit activity
- **Intercepted fall is still a fall**



Definition for Fracture r/t a Fall, page J-28 has been updated- last sentence is NEW.

### J18000 – Any Falls since Admission or prior Assessment (OBRA, PPS, or discharge)

- If initial Admission MDS, review from Admission date to ARD
- Otherwise, review from day **after** ARD of last MDS assessment (OBRA, PPS, or discharge) to ARD of current MDS
- Review: All documents in medical record: incident reports, staff reports, etc.
- Code if reported or documented
- **0 = No:** No falls
- **1 = Yes:** Has fallen

### J19000 – #of Falls & Injury since Admission, or prior Assessment (OBRA, PPS, or discharge) - whichever is more recent

- Determine # of falls & level of fall-related injury
- **Minor** injury: skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains, any injury that causes c/o pain
- **Major** injury: bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematomas
- **Code each fall only once**
- **If multiple injuries in a single fall, code highest level of injury**

### J19000 –Falls / Injuries cont.

- Coding # of Falls for J1900A, B, C
  - 0 = none: No falls
  - 1 = one fall
  - 2 = two or more falls
- Coding # Injuries with Falls for J1900A, B, C
  - J1900A – No injury
  - J1900B – Minor Injury
  - J1900C – Major Injury



Example #2, page J-33 re-written.